

MONTANA LEGISLATIVE HISTORY

Chapter 638 19 87

Bill H _____ S 371 Original bill & history C

H. Committee on Business & Labor

Hearing Date(s) Mar 20 ☒ C

Mar 26 ☒ C

_____ C

_____ C

Date Out Mar 26 ☒ C

S. Committee on Public Health Welfare & Safety

Hearing Date(s) Feb 20 ☒ C

_____ C

_____ C

_____ C

Feb 21 ☒ C

Did this bill originate in an interim committee? Yes No

Committee _____

Report _____

Note: A conference committee
was appointed. Its minutes
are unavailable.

SENATE FINAL STATUS

4/02 SIGNED BY SPEAKER

4/02 TRANSMITTED TO GOVERNOR

4/07 SIGNED BY GOVERNOR

CHAPTER NUMBER 396 EFFECTIVE DATE: 7/01/87

SB 371 INTRODUCED BY REGAN, HIMSL
REGULATE PREFERRED PROVIDER ARRANGEMENTS

2/18 INTRODUCED
2/18 REFERRED TO PUBLIC HEALTH, WELFARE & SAFETY
2/20 HEARING
2/21 STATEMENT OF INTENT ADOPTED
2/21 COMMITTEE REPORT--BILL PASSED AS AMENDED
2/24 2ND READING PASSED 50 0
2/25 3RD READING PASSED 50 0

TRANSMITTED TO HOUSE
3/03 REFERRED TO HUMAN SERVICES & AGING
3/13 REREFERRED TO BUSINESS & LABOR
3/20 HEARING
3/27 COMMITTEE REPORT--BILL CONCURRED AS AMENDED
3/28 2ND READING CONCURRED 75 1
3/30 3RD READING CONCURRED 92 6

RETURNED TO SENATE WITH AMENDMENTS
4/03 2ND READING AMENDMENTS NOT CONCURRED 50 0
4/06 CONFERENCE COMMITTEE APPOINTED 50 0
4/15 CONFERENCE COMMITTEE REPORT
4/16 2ND READING CONFERENCE COMMITTEE
REPORT ADOPTED 50 0
4/17 3RD READING CONFERENCE COMMITTEE
REPORT ADOPTED 50 0

HOUSE
4/14 CONFERENCE COMMITTEE APPOINTED
4/15 CONFERENCE COMMITTEE REPORT
4/16 2ND READING CONFERENCE COMMITTEE
REPORT ADOPTED 96 0
4/17 3RD READING CONFERENCE COMMITTEE
REPORT ADOPTED 94 1

5/01 SIGNED BY PRESIDENT
5/01 SIGNED BY SPEAKER

5/01 TRANSMITTED TO GOVERNOR
5/11 SIGNED BY GOVERNOR
CHAPTER 638

SECTIONS 7, 12 -- EFFECTIVE DATE: 5/11/87

SECTIONS 1-6, 8-11 -- EFFECTIVE DATE: 10/01/87

SB 372 INTRODUCED BY PINSONEAULT
REVISE LEMON LAW PROCEDURES, I.E., DISPUTE
SETTLEMENT PROCEDURES INVOLVING NEW MOTOR
VEHICLE WARRANTIES

2/17 RULES SUSPENDED TO ALLOW INTRODUCTION
OF BILL AFTER DEADLINE
2/18 INTRODUCED
2/18 REFERRED TO BUSINESS & INDUSTRY
2/20 HEARING
2/21 COMMITTEE REPORT--BILL PASSED AS AMENDED
2/24 2ND READING PASSED AS AMENDED 50 0
2/25 3RD READING PASSED 50 0

1 *Senate* BILL NO. 371
2 INTRODUCED BY *Boyd*
3
4 A BILL FOR AN ACT ENTITLED: "AN ACT PERMITTING INSURERS TO
5 ENTER INTO AGREEMENTS WITH HEALTH CARE PROVIDERS AND TO
6 ISSUE POLICIES THAT INCLUDE INCENTIVES OR LIMIT
7 REIMBURSEMENT FOR UTILIZING SERVICES RENDERED BY PROVIDERS
8 WITH WHOM THE INSURER HAS AN AGREEMENT; AND PROVIDING AN
9 IMMEDIATE EFFECTIVE DATE."

10
11 BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF MONTANA:

12 Section 1. Short title. [Sections 1 through 4] may be
13 cited as the "Health Care Reimbursement Reform Act".

14 Section 2. Definitions. As used in [sections 1 through
15 4], the following definitions apply:

16 (1) "Health care services" means health care services
17 or products rendered or sold by a provider within the scope
18 of the provider's license or legal authorization, including
19 but not limited to hospital, medical, surgical, dental,
20 vision, and pharmaceutical services and products.

21 (2) "Insured" means an individual entitled to
22 reimbursement for expenses of health care services under a
23 policy or subscriber contract issued or administered by an
24 insurer.

25 (3) "Insurer" means an insurance company or a health

1 service corporation authorized in this state to issue
2 policies or subscriber contracts that reimburse an insured
3 for expenses of health care services.

4 (4) "Provider" means an individual or entity licensed
5 or legally authorized to provide health care services in
6 this state.

7 Section 3. Preferred provider agreements authorized.

8 (1) Notwithstanding any other provision of law to the
9 contrary, an insurer may:

10 (a) enter into agreements with providers relating to
11 health care services that may be rendered to the insurer's
12 insureds, including agreements relating to the amounts an
13 insured may be charged for services rendered; and

14 (b) issue or administer policies or subscriber
15 contracts in this state that:

16 (i) include incentives for the insured to use the
17 services of a provider that has entered into an agreement
18 with the insurer pursuant to subsection (1)(a); or

19 (ii) provide for reimbursement for health care services
20 only if the services are rendered by a provider that has
21 entered into an agreement with the insurer pursuant to
22 subsection (1)(a).

23 (2) [Sections 1 through 4] do not require that an
24 insurer negotiate or enter into agreements with any specific
25 provider or class of providers.

1 Section 4. Rules. The commissioner shall promulgate
2 rules prescribing reasonable standards relating to the
3 accessibility and availability of health care services for
4 persons insured under policies or contracts described in
5 [section 3(1)(b)(ii)].

6 Section 5. Codification instruction. Sections 1
7 through 4 are intended to be codified as an integral part of
8 Title 33, and the provisions of Title 33 apply to sections 1
9 through 4.

10 Section 6. Severability. If a part of this act is
11 invalid, all valid parts that are severable from the invalid
12 part remain in effect. If a part of this act is invalid in
13 one or more of its applications, the part remains in effect
14 in all valid applications that are severable from the
15 invalid applications.

16 Section 7. Effective date. This act is effective on
17 passage and approval.

-End-

1 STATEMENT OF INTENT

2 SENATE BILL 371

3 Senate Public Health, Welfare, and Safety Committee

4
5 A statement of intent is required for this bill because
6 section 6 authorizes the commissioner of insurance to
7 promulgate rules prescribing reasonable standards relating
8 to the accessibility and availability of health care
9 services for persons insured under policies or contracts
10 described in section 3. The legislature intends that the
11 rules adopted to implement this bill be designed to:

12 (1) foster accessibility and availability of health
13 care services; and

14 (2) protect Montana health care insurance consumers.

15 The legislature further intends that the commissioner
16 adopt rules to implement this act in accordance with
17 33-1-313, which permits the commissioner:

18 (1) to make only reasonable rules that do not extend,
19 modify, or conflict with any law of this state or with any
20 reasonable implication of such law; and

21 (2) to make or amend those rules only after a hearing
22 of which notice has been given as required by 33-1-703.

REFERENCE BILL
SB-371

SENATE BILL NO. 371

INTRODUCED BY REGAN, HIMSL

A BILL FOR AN ACT ENTITLED: "AN ACT PERMITTING INSURERS TO ENTER INTO AGREEMENTS WITH HEALTH CARE PROVIDERS AND TO ISSUE POLICIES THAT INCLUDE INCENTIVES OR----LIMIT REIMBURSEMENT FOR UTILIZING SERVICES RENDERED BY PROVIDERS WITH WHOM THE INSURER HAS AN AGREEMENT; AND PROVIDING AN IMMEDIATE APPLICABILITY DATE AND AN EFFECTIVE DATE."

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF MONTANA:

Section 1. Short title. [Sections 1 through 4 6 7] may be cited as the "Health-Care-Reimbursement-Reform PREFERRED PROVIDER AGREEMENTS Act".

SECTION 2. PURPOSE. THE PURPOSE OF [SECTIONS 1 THROUGH 7] IS TO ALLOW A HEALTH CARE INSURER PROVIDING DISABILITY INSURANCE BENEFITS TO NEGOTIATE AND CONTRACT WITH HEALTH CARE PROVIDERS TO:

(1) PROVIDE HEALTH CARE SERVICES TO ITS INSURED OR SUBSCRIBERS AT A REDUCTION IN THE FEES CUSTOMARILY CHARGED BY THE PROVIDER; OR

(2) ENTER INTO AGREEMENTS IN WHICH THE PARTICIPATING PROVIDERS ACCEPT NEGOTIATED FEES AS PAYMENT IN FULL FOR HEALTH CARE SERVICES THE HEALTH CARE INSURER IS OBLIGATED TO PROVIDE OR PAY FOR UNDER THE HEALTH BENEFIT PLAN.

Section 3. Definitions. As used in [sections 1 through 4 6 7], the following definitions apply:

(1) "EMERGENCY SERVICES" MEANS SERVICES PROVIDED AFTER SUFFERING AN ACCIDENTAL BODILY INJURY OR THE SUDDEN ONSET OF A MEDICAL CONDITION MANIFESTING ITSELF BY ACUTE SYMPTOMS OF SUFFICIENT SEVERITY (INCLUDING SEVERE PAIN) THAT WITHOUT IMMEDIATE MEDICAL ATTENTION THE SUBSCRIBER OR INSURED COULD REASONABLY EXPECT THAT:

(A) HIS HEALTH WOULD BE IN SERIOUS JEOPARDY;

(B) HIS BODILY FUNCTIONS WOULD BE SERIOUSLY IMPAIRED;

OR

(C) A BODILY ORGAN OR PART WOULD BE SERIOUSLY DAMAGED.

(2) "HEALTH BENEFIT PLAN" MEANS THE HEALTH INSURANCE POLICY OR SUBSCRIBER ARRANGEMENT BETWEEN THE INSURED OR SUBSCRIBER AND THE HEALTH CARE INSURER THAT DEFINES THE COVERED SERVICES AND BENEFIT LEVELS AVAILABLE.

(3) "HEALTH CARE INSURER" MEANS:

(A) AN INSURER THAT PROVIDES DISABILITY INSURANCE AS DEFINED IN 33-1-207;

(B) A HEALTH SERVICE CORPORATION AS DEFINED IN 33-30-101;

(C) A HEALTH MAINTENANCE ORGANIZATION [AS DEFINED IN SECTION 2 OF SENATE BILL NO. 353];

(D) A FRATERNAL BENEFIT SOCIETY AS DEFINED IN 33-7-102;

(E) AN ADMINISTRATOR AS DEFINED IN 33-17-601; OR

(F) ANY OTHER ENTITY REGULATED BY THE COMMISSIONER THAT PROVIDES HEALTH COVERAGE.

~~(1)(3)(4)~~ "Health care services" means health care services or products rendered or sold by a provider within the scope of the provider's license or legal authorization, including--but--not--limited-to-hospital-,medical-,surgical-, dental-,vision-,and-pharmaceutical-services-and-products OR SERVICES PROVIDED UNDER TITLE 33, CHAPTER 22, PART 7.

~~(2)(4)(5)~~ "Insured" means an individual entitled to reimbursement for expenses of health care services under a policy or subscriber contract issued or administered by an insurer.

~~(3)(5)--"Insurer"--means--an--insurance--company--or--a health-service-corporation-authorized-in-this-state-to-issue policies--or--subscriber-contracts-that-reimburse-an-insured for-expenses-of-health-care-services.~~

(6) "PREFERRED PROVIDER" MEANS A PROVIDER OR GROUP OF PROVIDERS WHO HAVE CONTRACTED TO PROVIDE SPECIFIED HEALTH CARE SERVICES.

(7) "PREFERRED PROVIDER AGREEMENT" MEANS A CONTRACT BETWEEN OR ON BEHALF OF A HEALTH CARE INSURER AND A PREFERRED PROVIDER.

~~(4)(6)(8)~~ "Provider" means an individual or entity licensed or legally authorized to provide health care

services in-this-state OR SERVICES COVERED WITHIN TITLE 33, CHAPTER 22, PART 7.

(9) "SUBSCRIBER" MEANS A CERTIFICATE HOLDER OR OTHER PERSON ON WHOSE BEHALF THE HEALTH CARE INSURER IS PROVIDING OR PAYING FOR HEALTH CARE COVERAGE.

Section 4. Preferred provider agreements authorized.
(1) Notwithstanding any other provision of law to the contrary, an A HEALTH CARE insurer may:

(a) enter into agreements with providers relating to health care services that may be rendered to the--insurer's insureds OR SUBSCRIBERS ON WHOSE BEHALF THE HEALTH CARE INSURER IS PROVIDING HEALTH CARE COVERAGE, including PREFERRED PROVIDER agreements relating to:

(I) the amounts an insured may be charged for services rendered; AND

(II) THE AMOUNT AND MANNER OF PAYMENT TO THE PROVIDER; and

(b) issue or administer policies or subscriber contracts in this state that:

~~(i)~~ include incentives for the insured to use the services of a provider that has entered into an agreement with the insurer pursuant to subsection (1)(a);-or-

~~(ii)-provide-for-reimbursement-for-health-care-services only--if--the--services--are-rendered-by-a-provider-that-has entered-into-an--agreement--with--the--insurer--pursuant--to~~

subsection-(1)(a)-

(2) A PREFERRED PROVIDER ARRANGEMENT AGREEMENT ISSUED OR DELIVERED IN THIS STATE MAY NOT UNFAIRLY DENY HEALTH BENEFITS FOR MEDICALLY-NECESSARY HEALTH CARE SERVICES COVERED EXPENSES.

(3) [Sections 1 through 4 6 7] do not require that an insurer negotiate or enter into agreements with any specific provider or class of providers.

SECTION 5. INCENTIVES IN HEALTH BENEFIT PLANS. (1) A HEALTH CARE INSURER MAY ISSUE A POLICY OR A HEALTH BENEFIT PLAN THAT PROVIDES FOR INCENTIVES FOR COVERED PERSONS TO USE THE HEALTH CARE SERVICES OF PREFERRED PROVIDERS.

(2) THE POLICY OR HEALTH BENEFIT PLAN MUST CONTAIN AT LEAST:

(A) A PROVISION THAT IF A COVERED PERSON RECEIVES EMERGENCY CARE FOR SERVICES SPECIFIED IN THE PREFERRED PROVIDER ARRANGEMENT AGREEMENT AND CANNOT REASONABLY REACH A PREFERRED PROVIDER, THE CARE RENDERED DURING THE COURSE OF THE EMERGENCY WILL BE REIMBURSED AS THOUGH THE COVERED PERSON HAD BEEN TREATED BY A PREFERRED PROVIDER; AND

(B) A PROVISION THAT CLEARLY IDENTIFIES THE DIFFERENCE IN BENEFIT LEVELS FOR HEALTH CARE SERVICES OF A PREFERRED PROVIDER AND BENEFIT LEVELS FOR THE SAME HEALTH CARE SERVICES OF A NONPREFERRED PROVIDER.

(2) A HEALTH CARE INSURER MAY NOT REQUIRE HOSPITAL

STAFF PRIVILEGES AS CRITERIA FOR DESIGNATION AS A PREFERRED PROVIDER IN A PREFERRED PROVIDER AGREEMENT.

SECTION 6. PERMISSIBLE PROVISIONS IN PROVIDER ARRANGEMENTS AGREEMENTS, INSURANCE POLICIES, AND SUBSCRIBER CONTRACTS. (1) A PROVIDER ARRANGEMENT AGREEMENT, INSURANCE POLICY, OR SUBSCRIBER CONTRACT ISSUED OR DELIVERED IN THIS STATE MAY CONTAIN CERTAIN OTHER COMPONENTS DESIGNED TO CONTROL THE COST AND IMPROVE THE QUALITY OF HEALTH CARE FOR POLICYHOLDERS INSURED AND SUBSCRIBERS, INCLUDING:

(A) A PAYMENT DIFFERENTIAL OF NOT MORE THAN 25% BETWEEN USE OF PROVIDERS WITH ARRANGEMENTS WITH THE HEALTH CARE INSURER AND USE OF PROVIDERS WITHOUT SUCH ARRANGEMENTS. THE COMMISSIONER MAY BY RULE DETERMINE APPROPRIATE DIFFERENTIALS BETWEEN COPAYMENTS, DEDUCTIBLES, AND OTHER COST SHARING ARRANGEMENTS PROVISION SETTING A PAYMENT DIFFERENCE FOR REIMBURSEMENT OF A NONPREFERRED PROVIDER AS COMPARED TO A PREFERRED PROVIDER. IF THE HEALTH BENEFIT PLAN CONTAINS A PAYMENT DIFFERENCE PROVISION, THE PAYMENT DIFFERENCE MAY NOT EXCEED 25% OF THE REIMBURSEMENT LEVEL AT WHICH A PREFERRED PROVIDER WOULD BE REIMBURSED.

(B) CONDITIONS, NOT INCONSISTENT WITH OTHER PROVISIONS OF [SECTIONS 1 THROUGH 6], DESIGNED TO GIVE POLICYHOLDERS OR SUBSCRIBERS AN INCENTIVE TO CHOOSE A PARTICULAR PROVIDER.

(2) ALL TERMS OR CONDITIONS OF A PROVIDER ARRANGEMENT, AN INSURANCE POLICY, OR SUBSCRIBER CONTRACT, EXCEPT THOSE

1 ALREADY APPROVED BY THE COMMISSIONER, ARE SUBJECT TO THE
 2 PRIOR APPROVAL OF THE COMMISSIONER.

3 Section 7. Rules. The commissioner shall promulgate
 4 rules ~~prescribing--reasonable--standards--relating--to--the~~
 5 ~~accessibility--and--availability-of-health-care-services-for~~
 6 ~~persons--insured--under--policies--or--contracts--described--in~~
 7 NECESSARY TO IMPLEMENT THE PROVISIONS OF [section
 8 3(i)(b)(iii) SECTIONS 1 THROUGH 6 7].

9 Section 8. Codification instruction. Sections 1
 10 through 4 6 7 are intended to be codified as an integral
 11 part of Title 33, and the provisions of Title 33 apply to
 12 sections 1 through 4 6 7.

13 SECTION 9. COORDINATION INSTRUCTION. IF SENATE BILL
 14 NO. 353, INCLUDING THE DEFINITION OF "HEALTH MAINTENANCE
 15 ORGANIZATION", IS NOT PASSED AND APPROVED, THE BRACKETED
 16 LANGUAGE IN SECTION 3(3)(C) OF THIS ACT IS VOID.

17 Section 10. Severability. If a part of this act is
 18 invalid, all valid parts that are severable from the invalid
 19 part remain in effect. If a part of this act is invalid in
 20 one or more of its applications, the part remains in effect
 21 in all valid applications that are severable from the
 22 invalid applications.

23 SECTION 11. APPLICABILITY -- FILING WITH COMMISSIONER.
 24 ON OR BEFORE JANUARY 1, 1988, A HEALTH CARE INSURER
 25 PERFORMING THE FUNCTIONS ENUMERATED IN THIS ACT SHALL NOTIFY

1 THE COMMISSIONER OF ITS EXISTENCE AND CONTINUE TO OPERATE
 2 SUBJECT TO THE PROVISIONS OF THIS ACT.

3 Section 12. Effective date. ~~This act is~~ SECTION 6 7
 4 AND THIS SECTION ARE effective on passage and approval.

-End-

MINUTES OF THE MEETING
PUBLIC HEALTH, WELFARE & SAFETY COMMITTEE
MONTANA STATE SENATE

February 20, 1987

The meeting of the Senate Public Health, Welfare and Safety Committee was called to order by Chairman Dorothy Eck on February 20, 1987, at 12:40 P.M. in Room 325 of the State Capitol.

ROLL CALL: All members were present, except for Senator Tom Hager.

FURTHER CONSIDERATION OF S.B. 353: Sen. Tom Rassmussen explained the action of the subcommittee and stated that the subcommittee blended the two bills together.

Karen Renne explained the new amendments to S.B. 353, which included recommended sections of S.B. 349. See amendments on attached Standing Committee Report.

David Evenson, Montana University System, stated that Commissioner of Higher Education foresees problems with Section 29 on dual choice. Younger, healthy people would probably choose to join an HMO, while older people would stay in the same indemnity program at an increased cost to the employer. They would like to see employers have the ability to negotiate with HMO's and place them into a bid situation.

Sen. Rassmussen: I would like Blue Cross to comment on the last amendment.

Ans: Chuck Butler: The Federal HMO Act, under which HMO's seek to be federally qualified, can go in and mandate that the University system consider their program. Under this act, any state HMO could do that, too.

Mona Jamison, Lobbyist, Rocky Treatment Center, stated that the committee should think about the Federal Government requiring that HMO coverage be mandatorially offered. If this bill passes, all employers with twenty-five employees or more will have to offer HMO coverage. Because the young and healthy will probably choose an HMO and the older, less healthy will need to stay with the regular health insurance industry, this could have quite an impact on the Montana health insurance industry. The committee needs to consider this. No one has yet had an opportunity to examine this.

Sen. Eck: Does this mean that every employer group must offer this?

Kathy Irigoin: Yes, if the employer has twenty-five or more employees. The Federal HMO Act does have this provision, which the Federal Government provided to get HMO's off the ground. The Federal Act may be repealed.

Sen. Rassmussen: I would like to move the additional amendments: Page 53, lines 5-20. We should have the option in our law of not mandating employers, but providing them with flexibility.

Chuck Butler: You would not have to offer a Federally qualified HMO, if you have a choice.

Sen. Eck: Would employers have to offer HMO's to employers, if they have twenty-five employees?

state Energy board?

Mr. Howe: Yes, we are involved.

Sen. Eck: How is that funded?

Mr. Howe: The governor's office is involved through Brock Haydon. The board has several committees, one dealing with nuclear waste; and the governor's budget does provide monies, about \$15,000 toward support.

Sen. Eck: has Montana been asked previously to participate in this pact?

Sen. Walker: The pact originated with Washington, Oregon and California.

Sen. Eck: Hugh Zackheim from the EQC has participated.

Sen. Williams: Is there a contact in other states?

Sen. Walker: Yes, the departments of health and others.

Sen. Rassmussen: How many states that are eligible participate now?

Sen. Walker: Six.

Sen. Rassmussen: Does this do the same thing as the Western Interstate contract?

Dr. Drinan: This organization is a more independent organization. Other agreements have been contracted out by the Department of Energy.

Sen. Eck: I would like to call Hugh Zackheim to the committee. We will take executive action on this this evening.

Sen. Walker closed by stating that the bill offers a good concept. It determines who is going to handle the transportation problem. The Western Energy Compact has not been working on this. This group does work and participate.

CONSIDERATION OF SENATE BILL NO. 371: Sen. Regan, District # 47, sponsor of S.B. 371, stated that the purpose of the bill in developing preferred providers is to develop an efficient system of health care delivery. Preferred providers fees are generally less and the state can enter into agreements with preferred providers. They provide 100% coverage of lesser fees as opposed to 80% coverage of higher fees.

PROPOSERS: Tom Hopgood, Health Insurance Association of America, stated that they offer full support of the benefits to the consumer that the Preferred Providers concept offers.

Jerome Loendorf: Montana Medical Association, stated that they had not had a chance to review the bill, but that it seems to be a contractual arrangement between a preferred provider and an organization.

William Leary, Montana Hospital Association, stated that they are in support of the bill because it seems to be permissive, not mandatory. It will probably be utilized only in communities with two or more hospitals. There is no significant advantage in com-

munities with only one hospital. The bill seems to be well written.

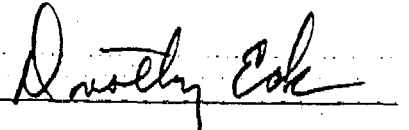
Chuck Butler, Blue Cross-Blue Shield, stated that the bill makes it possible for commercial companies to do what Blue Cross has been doing for the last forty years. He suggested that the title on Line 6, P. 7, should include incentives or limit reimbursements, because that is also in the HMO statute. If the intent of the bill is to let insurers contract with providers to offer services, then that should be included in other legislation.

Sen. Rassmussen: What about freedom of choice provisions? If A, B, & C can get in, can D? How do you determine who gets to be in the preferred provider group?

Sen. Regan: The bill dosen't speak to all that yet. Karen Renne has proposed an amendment to make an effective date.

ACTION ON S.B. 371: Sen. Meyer moved that the amendment DO PASS. The vote in favor was unanimous. Sen. Hims1 moved that the bill DO PASS AS AMENDED. The vote in favor was unanimous. Sen. McLane moved that the statement of intent DO PASS. The vote in favor was unanimous.

The meeting was adjourned at 2:55 P.M.



CHAIRMAN

ROLL CALL

Public Health, Welfare and Safety COMMITTEE

50th LEGISLATIVE SESSION -- 1987

Date 2-20-87

NAME	PRESENT	ABSENT	EXCUSED
Dorothy Eck	X		
Bill Norman	X		
Bob Williams	X		
Darryl Meyer	X		
Eleanor Vaughn	X		
Tom Rasmussen	X		
Judy Jacobson	X		
Harry H. "Doc" McLane	X		
Matt Himsl	X		
Tom Haqer			

Each day attach to minutes.

DATE _____

COMMITTEE ON

VISITORS' REGISTER

[illegible]

(Please leave prepared statement with Secretary)

MINUTES OF THE MEETING
PUBLIC HEALTH, WELFARE AND SAFETY COMMITTEE
MONTANA STATE SENATE

February 20, 1987

The meeting of the Senate Public Health, Welfare and Safety Committee was called to order by Chairman Dorothy Eck on February 20, 1987, at 7:40 P.M. in room 410 of the State Capitol.

ROLL CALL: All members were present, except for Senators Hager and Himsl.

FURTHER CONSIDERATION OF SENATE BILL NO. 351: Sen. Eck: The question seems to be whether the member should be assigned to the EQC, to an executive agency, or at all.
Brace Hayden, Western Interstate Energy: It could be handled by either the executive branch or the legislative branch.

Sen. Rassmussen: Do you feel that the executive branch isn't monitoring this adequately at this time?

Brace Hayden: The executive branch does many functions described in the bill, but it can't do all the functions in the bill. It is not a member of any western compact. WIE is simply a federal agency that sends out information.

Sen. Rassmussen: Would the Department of Health be the appropriate agency to have involved?

Mr. Hayden: The bill would have a member of the legislative branch participate in gathering information.

Dr. Drinan: The biggest problem for the department of Health is being spread too thin. We may need another staff person, and the only person educationally qualified in the state is Larry Lloyd. When we helped to design the bill, we thought it would be more appropriate to have a legislative representative on the board rather than a state official because he will probably go back to the legislature for action.

Brace Hayden: We get one notice a week of radioactive material going through the state, and the Governor needs to know this. This person will rely on the expertise of the Health Department.

Sen. Eck: Should Sec. 2, P.7, be deleted at this time?

Dr. Drinan: We could take this to the House where we could work out the appropriation further.

Sen. Jacobson moved to delete everything in the title following the word "management" on Line 6 and Section 2.

Sen. Rassmussen: Are we letting the House decide? I think it is appropriate for the Department of Health to handle this.

Dr. Drinan: We are doing that already and I would have no problem with that, if that would satisfy the intent of the bill.

7:40 P.M.

George Ochenski, MEIC: Should Sen. Walker speak about what you are going to do to replace the stricken section?

Sen. Rassmussen: I would make a substitute motion to plug in the DHES in place of the EQC and accept the DHES amendment.

Dr. Drinan: Sen. Walker does not object to that.

ACTION ON S.B. 351: The amendments proposed by the DHES were moved (by Sen. Rassmussen) and passed unanimously.

Sen. Rassmussen moved that S.B. 351 DO PASS AS AMENDED. The vote in favor was unanimous.

FURTHER ACTION ON S.B. 371: Sen. Regan proposed some additional amendments to S.B. 371. They included amending the title of the bill, amendments to Lines 19-22, a new Sec. 4, P.2. Chairman Eck called for a motion to reconsider the afternoon action. Sen. Williams so moved. The motion carried unanimously.

Sen. Jacobson moved that the amendments be adopted. The motion carried unanimously.

Sen. Jacobson moved that S.B. 371 DO PASS AS AMENDED. The motion carried unanimously.

ACTION ON S.B. 353: Karen Renne addressed the amendments to the amendments on Sections 5 and 7. Steve Brown, BC-BS, stated that that is proprietary information which is Blue Cross's objection. There could be a confidentiality provision for that information, but the information may still have to be disclosed, enabling another company to take advantage of the work a previous company has done.

Jim Bourhardt, Chief Examiner, Auditor's Office, stated that they would like to know if the companies have reasonable plans, especially if they are a new start-up company. confidentiality of information will be a problem, if information on what one company does is available to other companies. Large companies will have the advantage in that they will have computer and auditing systems already available.

Steve Brown stated that if you lay out what you are charging a patient, that will be very valuable information to a competitor. Kathy Irigoine, Auditor's Office, stated that all that information is not required, but that other information like the premium charge will be. North Dakota has adopted the NAIC model, which is where this language came from.

Sen. Rassmussen moved to keep in the language to delete Amendment No. 7. The motion failed.

Amendment No. 25 is the "guts" of an HMO and they need to have it to operate. That amendment died for lack of a motion.

Sen. Rassmussen: What about quality of care?

ROLL CALLPublic Health, Welfare and Safety COMMITTEE

50th LEGISLATIVE SESSION -- 1987

Date 2-20-877:30 PM

NAME	PRESENT	ABSENT	EXCUSED
Dorothy Eck	X		
Bill Norman	X		
Bob Williams	X		
Darryl Meyer	X		
Eleanor Vaughn	X		
Tom Rasmussen	X		
Judy Jacobson	X		
Harry H. "Doc" McLane	X		
Tom Hager			
Matt Himsl			

Each day attach to minutes.

STANDING COMMITTEE REPORT

SCRSB371

February 21, 1987

MR. PRESIDENT

Public Health, Safety, and Welfare

We, your committee on.....

Senate Bill

371

having had under consideration..... No.....

FIRST

YELLOW

reading copy ()
color

REGULATE PREFERRED PROVIDER ARRANGEMENTS

Respectfully report as follows: That..... Senate Bill..... No. 371.....

BE AMENDED AS FOLLOWS:

1. Title, lines 6 and 7.

Following: "INCENTIVES"

Strike: "OR LIMIT REIMBURSEMENT"

2. Title, line 9.

Strike: "IMMEDIATE"

3. Page 1, following line 15.

Insert: "(1) "Emergency services" means services provided after suffering an accidental bodily injury or the sudden onset of a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) that without immediate medical attention the subscriber or insured could reasonably expect that:

- (a) his health would be in serious jeopardy;
- (b) his bodily functions would be seriously impaired; or
- (c) a bodily organ or part would be seriously damaged.

(2) "Health benefit plan" means the health insurance policy or subscriber arrangement between the insured or subscriber and the health care insurer that defines the covered services and benefit levels available."

Re-number: subsequent subsections

DO PASS

DO NOT PASS

CONTINUED

Chairman.

February 21,

87

19.....

4. Page 2, lines 15 and 16.

Strike: " (1) "

5. Page 2, line 16.

Strike: "; or "

Insert: "."

6. Page 2, lines 19 through 22.

Strike: subsection (1) in its entirety

Insert: "(2) A preferred provider arrangement issued or delivered in this state may not unfairly deny health benefits for medically necessary covered expenses."

Re-number: subsequent subsection

7. Page 3, line 1.

Insert: "Section 4. Incentives in health benefit plans.

(1) A health care insurer may issue a policy or a health benefit plan that provides for incentives for covered persons to use the health care services of preferred providers.

(2) The policy or health benefit plan must contain at least a provision that if a covered person receives emergency care for services specified in the preferred provider arrangement and cannot reasonably reach a preferred provider, the care rendered during the course of the emergency will be reimbursed as though the covered person had been treated by a preferred provider.

Section 5. Permissible provisions in provider arrangements, insurance policies, and subscriber contracts.

(1) A provider arrangement, insurance policy, or subscriber contract issued or delivered in this state may contain certain other components designed to control the cost and improve the quality of health care for policyholders and subscribers, including:

(a) a payment differential of not more than 25% between use of providers with arrangements with the health care insurer and use of providers without such arrangements. The commissioner may by rule determine appropriate differentials between copayments, deductibles, and other cost-sharing arrangements.

CONTINUED

February 21, 1987

19.....

(b) conditions, not inconsistent with other provisions of [sections 1 through 6], designed to give policyholders or subscribers an incentive to choose a particular provider.

(2) All terms or conditions of a provider arrangement, insurance policy, or subscriber contract are subject to the prior approval of the commissioner."

Renumber: subsequent sections.

8. Page 3, line 5.

Strike: "section 3(1)(b)(ii)"

Insert: "sections 1 through 6"

9. Page 3, line 7.

Following: "through"

Strike: "4"

Insert: "6"

10. Page 3, line 9.

Following: "through"

Strike: "4"

Insert: "6"

11. Page 3, line 16.

Following: "date."

Strike: "This act is"

Insert: "Section 6 and this section are"

AND AS AMENDED,
DO PASS

STATEMENT OF INTENT ADOPTED AND ATTACHED

Senator XXX

February 21, 1987

MR. PRESIDENT,

WE, YOUR COMMITTEE ON PUBLIC HEALTH, WELFARE, AND SAFETY, HAVING HAD UNDER CONSIDERATION SENATE BILL NO. 371, ATTACH THE FOLLOWING STATEMENT OF INTENT:

STATEMENT OF INTENT
SENATE BILL NO. 371

A statement of intent is required for this bill because section 6 authorizes the commissioner of insurance to promulgate rules prescribing reasonable standards relating to the accessibility and availability of health care services for persons insured under policies or contracts described in section 3. The legislature intends that the rules adopted to implement this bill be designed to:

- (1) foster accessibility and availability of health care services; and
- (2) protect Montana health care insurance consumers.

The legislature further intends that the commissioner adopt rules to implement this act in accordance with 33-1-313, which permits the commissioner:

- (1) to make only reasonable rules that do not extend, modify, or conflict with any law of this state or with any reasonable implication of such law; and
- (2) to make or amend those rules only after a hearing of which notice has been given as required by 33-1-703.

MINUTES OF THE MEETING
BUSINESS AND LABOR COMMITTEE
50TH LEGISLATIVE SESSION

March 20, 1987

The meeting of the Business and Labor Committee was called to order by Chairman Les Kitselman on March 20, 1987 at 8:00 a.m. in room 312-F of the state capitol.

ROLL CALL: All members were present.

EXECUTIVE ACTION

ACTION ON SENATE BILL NO. 250

Rep. Thomas moved that Senate Bill No. 250 BE CONCURRED IN. The motion carried unanimously.

Rep. Spaeth will carry the bill in the House.

ACTION ON SENATE BILL NO. 341

Rep. Brandewie moved that Senate Bill No. 341 BE CONCURRED IN.

Rep. Thomas moved the amendments to Senate Bill No. 341. The motion carried unanimously.

Rep. Brandewie moved that Senate Bill No. 341 BE CONCURRED IN AS AMENDED. The motion carried unanimously.

Rep. Simon will sponsor the bill in the House.

ACTION ON SENATE BILL NO. 298

Rep. Hansen moved that Senate Bill No. 298 BE CONCURRED IN.

Rep. Hansen moved the amendments to Senate Bill No. 298. The motion carried with 8 opposed.

Rep. Cohen moved that Senate Bill No. 298 BE TABLED. The motion failed 11 to 7.

Rep. Driscoll moved that Senate Bill 298 BE CONCURRED IN AS AMENDED. The motion carried.

Rep. Bardanouve will sponsor the bill in the House.

ACTION ON SENATE BILL NO. 360

Rep. Glaser moved that Senate Bill No. 360 BE CONCURRED IN. The motion passed unanimously.

Butler submitted proposed amendments and a promotional flier explaining their HMO program. Exhibit Nos. 7 and 8.

OPPONENTS

None.

QUESTIONS

Rep. Wallin asked Mr. Duncan to explain how the cost effectiveness of HMO programs. Mr. Duncan responded that the cost effectiveness is difficult to quantify in terms of dollars and cents. He said the HMO product that is offered is traditionally very competitive cost wise, and that the cost effectiveness of all HMO's are found in the fact that the utilization controls that are utilized in the HMO product is a means of controlling unnecessary hospitalizations, physician services or ancillary services.

Rep. Wallin asked at what point did the HMO organizations become attractive. Mr. Duncan responded that from experiences shown in the industry HMO's become attractive when it can be shown to employers, who are traditionally buying that health care product for their employees, and can have a significant number of physicians that are going to be able to offer the health care services to their employees.

Rep. Wallin asked what was the largest hospital in Montana that has HMO that would be willing to accept patients, for example, from Helena. Chuck Butler responded that HMO Montana have patients and members from Lewis and Clark County that could be treated at any hospital in the state of Montana and their services would be reimbursed.

CLOSING

Sen. Meyer stated that a lot of work had been done attempting to make this a good bill, which would give consumers financially sound HMO program in Montana.

SENATE BILL NO. 371 - Regulate Preferred Provider Arrangements, sponsored by Senator Pat Regan, Senate District No. 47, Billings. Senator Regan stated this bill allows insurers to enter into agreements with health care providers and to issue policies that include incentives for utilizing services rendered by providers with whom the insurer has an agreement, or they may limit reimbursements if they do not use that service. She said under current law there are no provisions for this kind of statute and have always used freedom of choice of practitioner. She commented this bill would not prohibit freedom of choice, but rather would award a person if the preferred provider was used. She added that industry and she agrees with the amendments proposed by the State Auditor's Office.

PROPOSERS

Kathy Irigoin, State Auditor's Office, submitted written testimony and amendments. Exhibit Nos. 9 and 10.

Steve Brown, representing Blue Cross/Blue Shield. Mr. Brown stated they support this bill and submitted proposed amendments. Exhibit No. 11.

Tom Hopgood, representing Health Insurance Association of America, also submitted amendments for clarification of the proposed legislation. Exhibit No. 12.

Steve Waldron, representing Mental Health Association. Mr. Waldron explained his amendments to the bill. Exhibit No. 13.

Bill Leary, representing Montana Hospital Association. Mr. Leary stated they support the intent of this bill as long as it remains in a permissive situation, rather than mandatory.

Pat Harper, representing Montana Psychological Association. Ms. Harper submitted written testimony. Exhibit No. 14.

Joan Rebish, Montana Mental Health Council Association, expressed support for the bill and the amendments proposed by Mr. Waldron which would give the kind of protection that the consumer needs.

Joy McGrath, representing Mental Health Association of Montana. Ms. McGrath expressed support for the bill and the amendments.

Ann Scott, representing Montana Chemical Dependency Association, expressed support for the bill and the amendments presented by Mr. Waldron.

Dennis Duncan, representing Montana Medical Association, expressed support for the bill which would provide a choice in the health care market. He asked for consideration that not all of the amendments proposed to the legislation be adopted so that the employer has a true choice and the employer and employee can choose what is best for them.

QUESTIONS

Rep. Driscoll asked Senator Regan what protection would there be for the employee that lives in a small rural community and the provider is in a larger community such as Billings. Senator Regan responded that there is a provision for emergency services if the insured cannot reasonably reach a preferred provider.

Rep. Hansen asked if this bill was permissive in what health care system was used. Senator Regan responded that this bill is not an attempt to take over the health care system, it is entirely permissive, with a lot of freedom of choice.

Chairman Kitselman asked Senator Regan to comment on the absence in this bill of the provisions for the licensure of the agents or distributors of this particular product. Senator Regan responded the insurance company will contract with health care providers that are licensed within the state. Ms. Irigoin responded that one of the distinctions between an HMO and a PPO act is that a group of physicians can form an HMO, and they want them to use licensed agents to explain the program to the people they enroll. She said this bill only permits insurance companies, health service corporations, and all of those that are already subject to the various parts of the insurance code requiring their representatives to be licensed, so it wasn't necessary to include a licensing provision in this bill.

CLOSING

Sen. Regan apologized for all the amendments, and she hoped the subcommittee could work on them.

Chairman Kitselman referred Senate Bill Nos. 353 and 371 to a subcommittee composed of Reps. Thomas, Brown, and Kitselman, with Rep. Kitselman as chairman.

HOUSE BILL NO. 884 - Payroll Tax to Fund Workers' Comp. Plan No. 3: Sale of Bonds, sponsored by Rep. Clyde Smith, House District No. 5, Kalispell. Rep. Smith stated the bill would provide a supplemental funding source for the Workers' Compensation State fund through an employer's payroll tax, provide for the sale of bonds to finance the unfunded liability of the state fund, provide that the employer's payroll tax is security for payment of the bonds, and to statutorily appropriate the payroll tax to pay principal, premium, and interest on the bonds.

Rep. Paula Darko, House District No. 2, Libby. Rep. Darko stated that her concern is that all the work that has been done will be lost if this bill does not pass. She said the fund will be defunct by fiscal year 1988. She commented that workers in the state will be taking benefit cuts, which will lower the rates for plan 3 that insures people with the workers' compensation fund. She said what is not seen is the advantage and the cost saving that plan 1 and 2 insureds will receive by these benefit cuts. She suggested the Committee weigh those cost savings against what those extra costs to employers will be. She added there are going to be lower premiums on plan 2 insureds, and those people who are insured with the private insurers will have about a 23% rate reduction in their premiums. She commented the people that

DAILY ROLL CALL

BUSINESS & LABOR

COMMITTEE

50th LEGISLATIVE SESSION -- 1987

Date MARCH 20, 1987

NAME	PRESENT	ABSENT	EXCUSED
REP. LES KITSELMAN, CHAIRMAN	✓		
REP. FRED THOMAS, VICE-CHAIRMAN	✓		
REP. BOB BACHINI	✓		
REP. RAY BRANDEWIE	✓		
REP. JAN BROWN	✓		
REP. BEN COHEN	✓		
REP. JERRY DRISCOLL	✓		
REP. WILLIAM GLASER	✓		
REP. LARRY GRINDE	✓		
REP. STELLA JEAN HANSEN	✓		
REP. TOM JONES	✓		
REP. LLOYD MCCORMICK	✓		
REP. GERALD NISBET	✓		
REP. BOB PAVLOVICH	✓		
REP. BRUCE SIMON	✓		
REP. CLYDE SMITH	✓		
REP. CHARLES SWYSGOOD	✓		
REP. NORM WALLIN	✓		

9
DATE 3-20-87
HB SB 371

WRITTEN TESTIMONY OF STATE AUDITOR'S OFFICE
SENATE BILL 371
March 20, 1987

I. Purpose/Background

Under existing law, only a health service corporation may enter into a preferred provider agreement. To date, the Montana Insurance Department has taken the position that the freedom of choice of practitioners law, which applies only to insurance companies (33-22-111, MCA), prevents them from entering into preferred provider agreements. If pressed, however, the Insurance Department may not prevail in its position, and preferred provider agreements may be formed without oversight.

Senate Bill 371 provides a regulatory framework for preferred provider agreements. The Insurance Department has amendments that Senator Regan, the sponsor of Senate Bill 371, has reviewed. They add definitions for terms used in the bill and modify language to conform with defined terms.

II. Explanation of amendments

Amendment 1 changes the title to the act to the "Preferred Provider Agreements Act".

Amendment 2 provides a purpose section.

Amendments 3 through 5 add definitions to terms used, but not defined, in Senate Bill 371 to decrease chances of litigation on the meaning of provisions contained in it.

Amendment 6 inserts a defined term--"health care insurer".

Amendments 7 and 8 insert clarifying language using defined terms.

Amendment 9 adds to the list of situations that may be addressed in preferred provider agreements.

Amendments 11 and 12 change the numbering within the "Incentives in Health Benefit Plans" section.

Amendments 13 and 15 add that a policy or health benefit plan must contain a provision that clearly identifies the differentials in benefit levels for health care services of a preferred provider and benefit levels for health care services of a nonpreferred provider.

Amendments 10, 14, 16, and 17 change the term "arrangements" to "agreements" because "agreements" is the term used in the rest of Senate Bill 371.

Amendment 18 adds an applicability section that requires PPOs already operating in the state to notify the commissioner of their existence and comply with Senate Bill 371.

Amendment 19 adds a coordination instruction providing that if Senate Bill 353 does not pass, the reference to it in the definition of "health care insurer" is void.

PROPOSED AMENDMENTS BY STATE AUDITOR'S OFFICE
SENATE BILL 371

1. Page 1, line 13.

Strike: "'Health Care Reimbursement Reform"

Insert: "Preferred Provider Agreements"

2. Page 1.

Following: line 15

Insert: "Section 2. Purpose. The purpose of [this act] is to allow health care insurers providing group disability insurance benefits to negotiate and contract with licensed health care providers either to provide health care services to its insureds or subscribers at a reduction in the fees customarily charged by the provider or to enter into agreements whereby the participating providers accept negotiated fees as payment in full for health care services that the health care insurer is obligated to pay for or provide under the health benefit plan."

Renumber: subsequent sections

3. Page 2.

Following: line 4

Insert: "(4) Health care insurer" means an insurer that provides disability insurance as defined in 33-1-207, a health service corporation as defined in 33-3--101, a health maintenance organization [as defined in section 1 of Senate Bill No. 353], a fraternal benefit society as defined in 33-7-102, or any other entity regulated by the insurance department that provides group health coverage."

Renumber: subsequent subsections

4. Page 2, lines 14 through 17.

Strike: subsections (5) in its entirety

Insert: "(7) 'Preferred provider' means a provider or group of providers who have contracted to provide specified health care services.

"(8) 'Preferred provider agreement' means a contract between or on behalf of a health care insurer and a preferred provider."

Renumber: subsequent subsections

5. Page 2.

Following: line 20

Insert: "(10) 'Subscriber' means a certificate holder or other person on whose behalf the health care insurer is paying for or providing health care coverage."

6. Page 2, line 23.

Strike: "an"

Insert: "a health care"

7. Page 2, line 25.
Strike: "the insurer's"

8. Page 3, line 1.
Following: "insureds"

Insert: "or subscribers on whose behalf the health care insurer is providing health care coverage"

Following: "including"

Insert: "preferred provider"

Following: "to"

Insert: "(i)"

9. Page 3, line 2.

Following: ";

Strike: "and"

Insert: "(ii) the amount and manner of payment to the provider;

"(iii) the review and control of utilization of health care services, if those agreements do not result in imposition of costs on insureds or subscribers by reason of postutilization denial of payment for services over which those insureds or subscribers have no control; and"

10. Page 3, line 12.

Strike: "ARRANGEMENT"

Insert: "agreement"

11. Page 3, line 18.

Strike: "(1)"

12. Page 3, line 22.

Strike: "(2)"

13. Page 3, line 23.

Following: "LEAST"

Insert: "the following: (1)"

14. Page 3, line 25.

Strike: "ARRANGEMENT"

Insert: "agreement"

15. Page 4, line 3.

Strike: ".

Insert: "; and

"(2) a provision that clearly identifies the differentials in benefit levels for health care services of a preferred provider and benefit levels for health care services of nonpreferred providers."

16. Page 4, line 12.

Strike: "ARRANGEMENTS"

Insert: "agreements"

17. Page 4, line 13.

Strike: "ARRANGEMENTS"

Insert: "agreements"

18. Page 5.

Following: line 2.

Insert: "Section 7. Applicability--filing with commissioner.

Within 60 days of [the effective date of this act], a person or organization performing the functions enumerated in [this act] shall notify the commissioner of its existence and continue to operate subject to applicable laws."

Renumber: subsequent sections

19. Page 5.

Following: line 6

Insert: "Section 9. Coordination instruction. If Senate Bill No. 353, including the definition of "health maintenance organization" is not passed and approved, the bracketed language in subsection (4) of section 3 of this act is void."

Renumber: subsequent sections

EXHIBIT 11

DATE 3-20-87

HB 3371

PROPOSED AMENDMENTS TO SENATE BILL 371

Senate Bill 371, Third Reading Copy, is hereby amended as follows:

1. Page: 3
Line: 12
Following: "A"
Strike: "PREFERRED PROVIDER ARRANGEMENT"
Insert: "health insurance policy or subscriber contract"
2. Page: 4
Line: 14
Strike: All of the language on line 14 through line 16
3. Page: 4
Line: 20
Following: "CONDITIONS OF"
Strike: "A PROVIDER ARRANGEMENT,"
Insert: "AN"
4. Page: 4
Line: 21
Following: "POLICY"
Strike: ", "
5. Page: 4
Beginning on Line 24:
Following: "rules"
Strike: "prescribing reasonable standards relating to the accessibility and availability of health care services for persons insured under"
Insert: "concerning"

NOTE: If the rulemaking amendment is adopted, a necessary change will have to be made in the statement of intent.

SB 371
AMENDMENTS

EXHIBIT 12

DATE 3-25-8

HB SB 371

1. Page 3, line 13.
Following: "DENY"
Insert: "or restrict"
2. Page 4, line 4.
Strike: Section 5 in its entirety.
ReNUMBER: remaining sections accordingly.

-
1. Page 4, line 11.
Strike: subsection (A), in its entirety.
ReNUMBER: all subsections accordingly.
 2. Page 4, line 20.
Following: "OF"
Strike: "A PROVIDER ARRANGEMENT"
Insert: "an"

-
1. Page 4, line 11.
Strike: subsection (A) in its entirety.
Insert: "(A) a provision setting a payment differential for reimbursement of a non-preferred provider as compared to a preferred provider. In the event such insurance policy of subscriber contract contains such a payment differential provision, the payment differential may not exceed 25% of the reimbursement level at which a preferred provider would be reimbursed."
 2. Page 4, line 20.
Following: "OF"
Strike: "A PROVIDER ARRANGEMENT"
Insert: "an"

SB 371 AMENDMENTS

EXHIBIT 13
DATE 3-25-87
HB 38371

Page 2, line 7, after license,
strike: or
insert: ,

Page 2, line 7, after authorization,
insert: , or providing services covered within title 33,
chapter 22, part 7

Page 2, line 19, after licensed,
strike: or
insert: ,

Page 2, line 19, after authorized,
insert: , or providing services covered within title 33,
chapter 22, part 7

3. Section 4 (2) [p. 3, line 14] - the addition of a definition of "MEDICALLY NECESSARY COVERED EXPENSES" would strengthen this statute.

The MPA recognizes that this is very important legislation and it is fully aware that PPO's are an emerging alternative to more traditional forms of health care delivery and reimbursement.

We do not yet know what the long term impact of PPO's will be on consumer access to quality health care or on the health care professions themselves.

We therefore support SB 371 and promise to work hard with the Committee and its subcommittee to make Montana's PPO law a strong and fair one with special protections for the health care consumer of Montana.

Thank you very much for your favorable consideration of SB 371, with the inclusion of strengthening anti-discrimination amendments.

Dr. Ann Hansen, practicing
psychologist in Helena

Pat Callbeck Harper, President
for Montana Psychological Association

The Montana Psychological Association represents 200 professional psychologists in the state of Montana in private and public sector treatment of mental illness. Out of its concern for cost-effective, innovative mental health care and freedom of choice for Montana health care consumers, the MPA supports Senate Bill 371.

Expenditures for health care in the U.S. totaled \$465 billion in 1985. Experts predict that the health care market will continue to evolve into a system based on fiscal considerations and competition, evidenced by the fact that employers and major purchasers are taking unprecedented steps to control health care costs through new cost-efficient ways of doing business with health care providers.

HMO's and PPO's (Preferred Provider Organizations) provide both important opportunities for cost-effective mental and physical health care as well as significant challenges to professional providers and consumers. In some states, certain practices of HMO's and PPO's restrict the delivery of some forms of mental health care to only physicians.

Because we feel that the Montana mental health care consumer is entitled to the optimum freedom of choice within the restrictions of the PPO agreements, we support the inclusion of strengthening "anti-discrimination" provisions into SB 371.

We offer two such provisions as amendments that have been enacted in other states in response to the practice of some PPO's:

1. "Willing Provider" provision - Section 4, new (4)
"No licensed provider, physician or hospital who agrees to the terms and conditions of the preferred provider agreement shall be denied the right to become a preferred provider to offer health services within the limits of their license."
2. Prohibit PPO's from requiring hospital privileges in order for a provider to be eligible - Sect. 4, new
"A Preferred Provider agreement issued or delivered in this state may not require hospital staff privileges as criteria for designation as a "preferred provider" in a Preferred Provider Organization."

(In other states this requirement has been used to exclude professional health care providers who are not physicians - those who carry hospital staff privileges - and therefore limit the choice of health care consumers to only physicians.)

VISITORS' REGISTER

BUSINESS AND LABOR

COMMITTEE

BILL NO. SENATE BILL NO. 371

DATE MARCH 20, 1987

SPONSOR SENATOR PAT REGAN

NAME (please print)	REPRESENTING	SUPPORT	OPPOSE
Jerome T. Loerding	Mt. Rehab. Assn	✓	
Pat Callbeck Harper	Mt. Psychological Assoc	✓	
Steve Walburn	Mt. Health Center	X	
Tom Hopgood	Health Ins. Assoc of Mt	X	
Bill LEARY	Mt. Hosp. Assn	X	
Rolando P. P. P.	Mt. Psychiatric Assoc	X	
Jay McVeth	Mt. Health Assoc	X	
Ted J. Davey	Mt. Mental Health Counselors Assn	✓	
Joan Reubich	Mt. Mental Health Council	✓	
Don Scott	Rocky Mtn. Treatment Center	✓	
Mike Murray	Chemical Dependency Programs of MT	✓	

IF YOU CARE TO WRITE COMMENTS, ASK SECRETARY FOR WITNESS STATEMENT FOR
PLEASE LEAVE PREPARED STATEMENT WITH SECRETARY.

MINUTES OF THE MEETING
BUSINESS AND LABOR COMMITTEE
50TH LEGISLATIVE SESSION

March 26, 1987

The meeting of the Business and Labor Committee was called to order by Chairman Les Kitselman on March 26, 1987 at 9:00 a.m. in Room 312-F of the State Capitol.

ROLL CALL: All members were present.

EXECUTIVE ACTION

ACTION ON HOUSE BILL 461

Rep. Dennis Nathe requested that House Bill No. 461 BE TABLED. The motion carried with three opposed.

ACTION ON SENATE BILL 353

Rep. Thomas moved SB 353 BE CONCURRED IN. Rep. Thomas moved to adopt the committee report and amendments. Chairman Kitselman discussed the amendments and mentioned that the Montana Psychological Association wanted to make sure that the board consisted of multi-disciplinary fields. He said the State Auditors language was accepted as amendment to the bill.

Rep. Brown commented that all the people had agreed to the amendments. The question was called. The motion carried with Reps. Jones and Brandewie opposed.

The question was called on the motion to be concurred as amended. The motion carried with Reps. Brandewie and Jones opposed.

ACTION ON SENATE BILL 371

Chairman Kitselman pointed out that one amendment on page 5 to page 6 that was not agreed on by the committee. Exhibit No. 1.

He said that was suggested by Steve Waldron but is the crux of what a preferred provider is. He said to compare the two programs, the health maintenance organization is a group of people that prepay and are assigned to a certain member health service group. The preferred provider organization are given a 25 percent differential in their medical charges and is selective on who belongs. He said the bill says a health care insurer may not deny a provider who agrees to the terms. He questioned whether the provider denied that

person would they be open to tort litigation on a discriminatory basis. He said the whole preferred provider agreement is based on discriminatory practices. He recommended that the language remain out of the bill. He said the bill is important to regulate the organization and provide consumer protection.

Rep. Swysgood questioned where one would take complaints. Chairman Kitselman explained it that a person would have to go to the preferred provider group to have the 25 percent differential. He pointed out that the discount encouraged employees to use their own facility. He said there were 93,000 contracts with Blue Cross Blue Shield. He said this still allows them to exist and provides consumer protection and regulation. He explained the pool core of doctors that deliver services under the preferred providers pay a lower fee. The question was called on adopting the committee report and amendments. The motion carried unanimously.

Rep. Thomas moved BE CONCURRED IN AS AMENDED. The motion carried unanimously.

ACTION ON SENATE BILL 315

Rep. Glaser, chairman of the subcommittee on SB 315, discussed the bill as a tool to protect workers and employers. He mentioned amendments proposed by the workers comp subcommittee. Rep. Glaser moved BE CONCURRED IN. Rep. Glaser moved the amendments.

He discussed amendments 12, 13, 14 and 15, on page 32 of the bill. Exhibit No. 2. He said there was a flaw in the bill. When someone is being rehabilitated and come back to where they can work the amendment says if there is a job opening and you are qualified the employer has an obligation to bring that person back. The person comes back as a new employee. He discussed amendment 49 that allows for termination of benefits for non-cooperation for rehabilitation services. He pointed out a concern by Rep. Driscoll. Rep. Driscoll commented on the rehabilitation disputes and how they are handled with portions being retroactive for administrative purposes.

Rep. Thomas moved the adoption of the subcommittee report and amendments. The question was called. The motion carried.

Rep. Glaser pointed out another amendment that needs to be considered on page 69 and 70. He said that after "provider" to insert "or the Department of Social and Rehabilitation Services". He pointed out that it was necessary to say Department of Social and Rehabilitation Services because it

DAILY ROLL CALL

BUSINESS & LABOR

COMMITTEE

50th LEGISLATIVE SESSION -- 1987

Date

3-26-87

NAME	PRESENT	ABSENT	EXCUSED
REP. LES KITSELMAN, CHAIRMAN	✓		
REP. FRED THOMAS, VICE-CHAIRMAN	✓		
REP. BOB BACHINI	✓		
REP. RAY BRANDEWIE	✓		
REP. JAN BROWN	✓		
REP. BEN COHEN	✓		
REP. JERRY DRISCOLL	✓		
REP. WILLIAM GLASER	✓		
REP. LARRY GRINDE	✓		
REP. STELLA JEAN HANSEN	✓		
REP. TOM JONES	✓		
REP. LLOYD MCCORMICK	✓		
REP. GERALD NISBET	✓		
REP. BOB PAVLOVICH	✓		
REP. BRUCE SIMON	✓		
REP. CLYDE SMITH	✓		
REP. CHARLES SWYSGOOD	✓		
REP. NORM WALLIN	✓		

STANDING COMMITTEE REPORT

EXHIBIT 1
DATE 3-26
RE SB371
MARCH 26 19 87

Mr. Speaker: We, the committee on BUSINESS AND LABOR

report SENATE BILL NO. 371

☐ do pass ☒ be concurred in ☒ as amended
☐ do not pass ☐ be not concurred in ☐ statement of intent attached

Les Kitse
REP. LES KITSELMAN Chairman

AMENDMENTS AS FOLLOWS:

1) Title, line 8
Following: "PROVIDING AN"
Insert: "APPLICABILITY DATE AND AN"

2) Page 1, line 12
Strike: "6"
Insert: "7"

3) Page 1, line 13
Strike: "Health Care Reimbursement Reform"
Insert: "Preferred Provider Agreements"

4) Page 1, line 14
Following: line 13
Insert: "Section 2. Purpose. The purpose of [sections 1 through 7] is to allow a health care insurer providing disability insurance benefits to negotiate and contract with health care providers to: (1) provide health care services to its insureds or subscribers at a reduction in the fees customarily charged by the provider; or (2) enter into agreements in which the participating providers accept negotiated fees as payment in full for health care services the health care insurer is obligated to provide or pay for under the health benefit plan."

Renumber: subsequent sections

5) Page 1, line 15
Strike: "6"
Insert: "7"

6) Page 2, line 5
Following: line 4
Insert: "(3) Health care insurer" means:
(a) an insurer that provides disability insurance as defined in 33-1-207;
(b) a health service corporation as defined in 33-30-101;

THIRD reading copy (BLUE color)

REP. KITSELMAN will sponsor

(c) a health maintenance organization [as defined in section 2 of Senate Bill no. 353];

(d) a fraternal, benefit society as defined in 33-7-102;

(e) an administrator as defined in 33-17-601; or

(f) any other entity regulated by the commissioner that provides health coverage."

Renumber: subsequent subsections

7) Page 2, lines 7 through 9

Following: "authorization" on line 7

Strike: the remainder of line 7, line 8 in its entirety, and line 9 through "products"

Insert: "or services provided under Title 33, chapter 22, part 7"

8) Page 2, lines 14 through 17

Strike: subsection (5) in its entirety

Insert: "(6) "Preferred provider" means a provider or group of providers who have contracted to provide specified health care services.

(7) "Preferred provider agreement" means a contract between or on behalf of a health care insurer and a preferred provider."

Renumber: subsequent subsection

9) Page 2, line 20

Strike: "in this state"

Insert: "or services covered within Title 33, chapter 22, part 7"

10) Page 2, line 21

Following: line 20

Insert: "(9) "Subscriber" means a certificate holder or other person on whose behalf the health care insurer is providing or paying for health care coverage."

11) Page 2, line 23

Strike: "an"

Insert: "a health care"

12) Page 2, line 25

Strike: "The insurer's"



Chairman.

13) Page 3, line 1

Following: "insureds"

Insert: "or subscribers on whose behalf the health care insurer is providing health care coverage"

Following: "including"

Insert: "preferred provider"

Following: "to"

Insert: ": (i)"

14) Page 3, line 2

Following: ";"

Insert: "~~and~~ (ii) the amount and manner of payment to the provider;"

15) Page 3, line 12

Strike: "ARRANGEMENT"

Insert: "agreement"

16) Page 3, line 14

Strike: "MEDICALLY NECESSARY"

Insert: "health care services"

Strike: "EXPENSES"

17) Page 3, line 15

Strike: "6"

Insert: "7"

18) Page 3, line 22

Strike: "(2)"

19) Page 3, line 23

Following: "LEAST"

Insert: ": (a)"

20) Page 3, line 25

Strike: "ARRANGEMENT"

Insert: "agreement"

21) Page 4, line 3

Following: "PROVIDER"

Insert: "; and

(b) a provision that clearly identifies the difference in benefit levels for health care services of a preferred provider and benefit levels for the same health care services of a nonpreferred provider"

SENATE BILL NO. 371

MARCH 26

19 87

Page 4 of 5

22) Page 4, line 4

Following: line 3

Insert: (2) A health care insurer may not require hospital staff privileges as criteria for designation as a preferred provider in a preferred provider agreement."

23) Page 4, line 5

Strike: "ARRANGEMENTS"Insert: "agreements"

24) Page 4, line 6

Strike: "ARRANGEMENT"Insert: "agreement"

25) Page 4, line 9

Strike: "POLICYHOLDERS"Insert: "insureds"

26) Page 4, lines 11 through 16

Following: "(A) A" on line 11

Strike: the remainder of line 11, lines 12 through 15 in their entirety and line 16 through "ARRANGEMENTS"

Insert: "provision setting a payment difference for reimbursement of a nonpreferred provider as compared to a preferred provider. If the health benefit plan contains a payment difference provision, the payment difference may not exceed 25% of the reimbursement level at which a preferred provider would be reimbursed"

27) Page 4, line 20

Following: "OF"Strike: " A PROVIDER ARRANGEMENT, "Insert: "an"

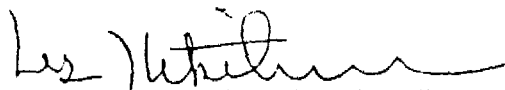
28) Page 4, line 21

Following: "POLICY"Strike: " "Following: "CONTRACT"Insert: "except those already approved by the commissioner,"

29) Page 4, line 24, through page 5, line 1

Following: "rules" on line 24

Strike: the remainder of line 24, lines 25 and 1 in their entirety

Insert: "necessary to implement the provisions of"


SENATE BILL NO. 371

MARCH 26

Page 5 of 5

19 87

30) Page 5, line 2

Strike: "6"

Insert: "7"

31) Page 5, line 4

Strike: "6"

Insert: "7"

32) Page 5, line 6

Strike: "6"

Insert: "7"

33) Page 5, line 7

Following: line 6

Insert: "Section 9. Coordination instruction. If Senate Bill No. 353, including the definition of "health maintenance organization", is not passed and approved, the bracketed language in section 3(3)(c) of this act is void."

Renumber: subsequent sections

34) Page 5, line 13

Following: line 12

Insert: "Section 11. Applicability -- filing with commissioner. On or before January 1, 1988, a health care insurer performing the functions enumerated in this act shall notify the commissioner of its existence and continue to operate subject to the provisions of this act."

Renumber: subsequent section

35) Page 5, line 13

Strike: "6"

Insert: "7"



Chairman

3-26-87

EXHIBIT

3.26

SB 371

SENATE BILL NO. 371

INTRODUCED BY REGAN, HIMSL

A BILL FOR AN ACT ENTITLED: "AN ACT PERMITTING INSURERS TO ENTER INTO AGREEMENTS WITH HEALTH CARE PROVIDERS AND TO ISSUE POLICIES THAT INCLUDE INCENTIVES OR---LIMIT REIMBURSEMENT FOR UTILIZING SERVICES RENDERED BY PROVIDERS WITH WHOM THE INSURER HAS AN AGREEMENT; AND PROVIDING AN IMMEDIATE APPLICABILITY DATE AND AN EFFECTIVE DATE."

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF MONTANA:

Section 1. Short title. [Sections 1 through 4 6 7] may be cited as the "Health-Care-Reimbursement-Reform PREFERRED PROVIDER AGREEMENTS Act".

SECTION 2. PURPOSE. THE PURPOSE OF [SECTIONS 1 THROUGH 7] IS TO ALLOW A HEALTH CARE INSURER PROVIDING DISABILITY INSURANCE BENEFITS TO NEGOTIATE AND CONTRACT WITH HEALTH CARE PROVIDERS TO:

(1) PROVIDE HEALTH CARE SERVICES TO ITS INSURED OR SUBSCRIBERS AT A REDUCTION IN THE FEES CUSTOMARILY CHARGED BY THE PROVIDER; OR

(2) ENTER INTO AGREEMENTS IN WHICH THE PARTICIPATING PROVIDERS ACCEPT NEGOTIATED FEES AS PAYMENT IN FULL FOR HEALTH CARE SERVICES THE HEALTH CARE INSURER IS OBLIGATED TO PROVIDE OR PAY FOR UNDER THE HEALTH BENEFIT PLAN.

Section 3. Definitions. As used in [sections 1 through 4 6 7], the following definitions apply:

(1) "EMERGENCY SERVICES" MEANS SERVICES PROVIDED AFTER SUFFERING AN ACCIDENTAL BODILY INJURY OR THE SUDDEN ONSET OF A MEDICAL CONDITION MANIFESTING ITSELF BY ACUTE SYMPTOMS OF SUFFICIENT SEVERITY (INCLUDING SEVERE PAIN) THAT WITHOUT IMMEDIATE MEDICAL ATTENTION THE SUBSCRIBER OR INSURED COULD REASONABLY EXPECT THAT:

(A) HIS HEALTH WOULD BE IN SERIOUS JEOPARDY;

(B) HIS BODILY FUNCTIONS WOULD BE SERIOUSLY IMPAIRED;

OR

(C) A BODILY ORGAN OR PART WOULD BE SERIOUSLY DAMAGED.

(2) "HEALTH BENEFIT PLAN" MEANS THE HEALTH INSURANCE POLICY OR SUBSCRIBER ARRANGEMENT BETWEEN THE INSURED OR SUBSCRIBER AND THE HEALTH CARE INSURER THAT DEFINES THE COVERED SERVICES AND BENEFIT LEVELS AVAILABLE.

(3) "HEALTH CARE INSURER" MEANS:

(A) AN INSURER THAT PROVIDES DISABILITY INSURANCE AS DEFINED IN 33-1-207;

(B) A HEALTH SERVICE CORPORATION AS DEFINED IN 33-30-101;

(C) A HEALTH MAINTENANCE ORGANIZATION [AS DEFINED IN SECTION 2 OF SENATE BILL NO. 353];

(D) A FRATERNAL BENEFIT SOCIETY AS DEFINED IN 33-7-102;

1 (E) AN ADMINISTRATOR AS DEFINED IN 33-17-601; OR

2 (F) ANY OTHER ENTITY REGULATED BY THE COMMISSIONER

3 THAT PROVIDES HEALTH COVERAGE.

4 ~~{1}{3}~~(4) "Health care services" means health care
5 services or products rendered or sold by a provider within
6 the scope of the provider's license or legal authorization,
7 ~~including--but--not--limited--to--hospital, medical, surgical,~~
8 ~~dental, vision, and pharmaceutical services and products~~ OR
9 SERVICES PROVIDED UNDER TITLE 33, CHAPTER 22, PART 7.

10 ~~{2}{4}~~(5) "Insured" means an individual entitled to
11 reimbursement for expenses of health care services under a
12 policy or subscriber contract issued or administered by an
13 insurer.

14 ~~{3}{5}--"Insurer"--means--an--insurance--company--or--a~~
15 ~~health-service-corporation-authorized-in-this-state-to-issue~~
16 ~~policies--or--subscriber-contracts-that-reimburse-an-insured~~
17 ~~for-expenses-of-health-care-services.~~

18 (6) "PREFERRED PROVIDER" MEANS A PROVIDER OR GROUP OF
19 PROVIDERS WHO HAVE CONTRACTED TO PROVIDE SPECIFIED HEALTH
20 CARE SERVICES.

21 (7) "PREFERRED PROVIDER AGREEMENT" MEANS A CONTRACT
22 BETWEEN OR ON BEHALF OF A HEALTH CARE INSURER AND A
23 PREFERRED PROVIDER.

24 ~~{4}{6}~~(8) "Provider" means an individual or entity
25 licensed or legally authorized to provide health care

1 ~~services in this state~~ OR SERVICES COVERED WITHIN TITLE 33,
 2 CHAPTER 22, PART 7.

3 (9) "SUBSCRIBER" MEANS A CERTIFICATE HOLDER OR OTHER
 4 PERSON ON WHOSE BEHALF THE HEALTH CARE INSURER IS PROVIDING
 5 OR PAYING FOR HEALTH CARE COVERAGE.

6 Section 4. Preferred provider agreements authorized.
 7 (1) Notwithstanding any other provision of law to the
 8 contrary, an A HEALTH CARE insurer may:

9 (a) enter into agreements with providers relating to
 10 health care services that may be rendered to ~~the--insurer's~~
 11 insureds OR SUBSCRIBERS ON WHOSE BEHALF THE HEALTH CARE
 12 INSURER IS PROVIDING HEALTH CARE COVERAGE, including
 13 PREFERRED PROVIDER agreements relating to:

14 (I) the amounts an insured may be charged for services
 15 rendered; AND

16 (II) THE AMOUNT AND MANNER OF PAYMENT TO THE PROVIDER;
 17 and

18 (b) issue or administer policies or subscriber
 19 contracts in this state that:

20 ~~{i}~~ include incentives for the insured to use the
 21 services of a provider that has entered into an agreement
 22 with the insurer pursuant to subsection (1)(a) ~~or.~~

23 ~~{ii}-provide-for-reimbursement-for-health-care-services~~
 24 ~~only--if--the--services--are-rendered-by-a-provider-that-has~~
 25 ~~entered-into-an--agreement--with--the--insurer--pursuant--to~~

1 subsection-(1)(a)-

2 (2) A PREFERRED PROVIDER ARRANGEMENT AGREEMENT ISSUED
 3 OR DELIVERED IN THIS STATE MAY NOT UNFAIRLY DENY HEALTH
 4 BENEFITS FOR MEDICALLY--NECESSARY HEALTH CARE SERVICES
 5 COVERED EXPENSES.

6 (2)(3) [Sections 1 through 4 6 7] do not require that
 7 an insurer negotiate or enter into agreements with any
 8 specific provider or class of providers.

9 SECTION 5. INCENTIVES IN HEALTH BENEFIT PLANS. (1) A
 10 HEALTH CARE INSURER MAY ISSUE A POLICY OR A HEALTH BENEFIT
 11 PLAN THAT PROVIDES FOR INCENTIVES FOR COVERED PERSONS TO USE
 12 THE HEALTH CARE SERVICES OF PREFERRED PROVIDERS.

13 (2) THE POLICY OR HEALTH BENEFIT PLAN MUST CONTAIN AT
 14 LEAST:

15 (A) A PROVISION THAT IF A COVERED PERSON RECEIVES
 16 EMERGENCY CARE FOR SERVICES SPECIFIED IN THE PREFERRED
 17 PROVIDER ARRANGEMENT AGREEMENT AND CANNOT REASONABLY REACH A
 18 PREFERRED PROVIDER, THE CARE RENDERED DURING THE COURSE OF
 19 THE EMERGENCY WILL BE REIMBURSED AS THOUGH THE COVERED
 20 PERSON HAD BEEN TREATED BY A PREFERRED PROVIDER; AND

21 (B) A PROVISION THAT CLEARLY IDENTIFIES THE DIFFERENCE
 22 IN BENEFIT LEVELS FOR HEALTH CARE SERVICES OF A PREFERRED
 23 PROVIDER AND BENEFIT LEVELS FOR THE SAME HEALTH CARE
 24 SERVICES OF A NONPREFERRED PROVIDER.

25 (2) A HEALTH CARE INSURER MAY NOT DENY A PROVIDER WHO

1 AGREES TO THE TERMS AND CONDITIONS OF A PREFERRED PROVIDER
 2 AGREEMENT THE RIGHT TO BECOME A PREFERRED PROVIDER.

3 (3) A HEALTH CARE INSURER MAY NOT REQUIRE HOSPITAL
 4 STAFF PRIVILEGES AS CRITERIA FOR DESIGNATION AS A PREFERRED
 5 PROVIDER IN A PREFERRED PROVIDER AGREEMENT.

6 SECTION 6. PERMISSIBLE PROVISIONS IN PROVIDER
 7 ARRANGEMENTS AGREEMENTS, INSURANCE POLICIES, AND SUBSCRIBER
 8 CONTRACTS. (1) A PROVIDER ARRANGEMENT AGREEMENT, INSURANCE
 9 POLICY, OR SUBSCRIBER CONTRACT ISSUED OR DELIVERED IN THIS
 10 STATE MAY CONTAIN CERTAIN OTHER COMPONENTS DESIGNED TO
 11 CONTROL THE COST AND IMPROVE THE QUALITY OF HEALTH CARE FOR
 12 POLICYHOLDERS INSURED AND SUBSCRIBERS, INCLUDING:

13 (A) A PAYMENT--DIFFERENTIAL--OF--NOT--MORE--THAN--25%
 14 BETWEEN--USE--OF--PROVIDERS--WITH--ARRANGEMENTS--WITH--THE--HEALTH
 15 CARE--INSURER--AND--USE--OF--PROVIDERS--WITHOUT--SUCH--ARRANGEMENTS.
 16 THE---COMMISSIONER---MAY---BY---RULE---DETERMINE---APPROPRIATE
 17 DIFFERENTIALS--BETWEEN--COPAYMENTS,--DEDUCTIBLES,--AND--OTHER
 18 COST-SHARING---ARRANGEMENTS PROVISION SETTING A PAYMENT
 19 DIFFERENCE FOR REIMBURSEMENT OF A NONPREFERRED PROVIDER AS
 20 COMPARED TO A PREFERRED PROVIDER. IF THE HEALTH BENEFIT PLAN
 21 CONTAINS A PAYMENT DIFFERENCE PROVISION, THE PAYMENT
 22 DIFFERENCE MAY NOT EXCEED 25% OF THE REIMBURSEMENT LEVEL AT
 23 WHICH A PREFERRED PROVIDER WOULD BE REIMBURSED.

24 (B) CONDITIONS, NOT INCONSISTENT WITH OTHER PROVISIONS
 25 OF [SECTIONS 1 THROUGH 6], DESIGNED TO GIVE POLICYHOLDERS OR

1 SUBSCRIBERS AN INCENTIVE TO CHOOSE A PARTICULAR PROVIDER.

2 (2) ALL TERMS OR CONDITIONS OF A-PROVIDER-ARRANGEMENT,
 3 AN INSURANCE POLICY, OR SUBSCRIBER CONTRACT EXCEPT THOSE
 4 ALREADY APPROVED BY THE COMMISSIONER ARE SUBJECT TO THE
 5 PRIOR APPROVAL OF THE COMMISSIONER.

6 Section 7. Rules. The commissioner shall promulgate
 7 rules prescribing--reasonable--standards--relating--to--the
 8 accessibility--and--availability-of-health-care-services-for
 9 persons-insured-under-policies--or--contracts--described--in
 10 NECESSARY TO IMPLEMENT THE PROVISIONS OF [section
 11 3(1)(b)(1) SECTIONS 1 THROUGH 6 7].

12 Section 8. Codification instruction. Sections 1
 13 through 4 6 7 are intended to be codified as an integral
 14 part of Title 33, and the provisions of Title 33 apply to
 15 sections 1 through 4 6 7.

16 SECTION 9. COORDINATION INSTRUCTION. IF SENATE BILL
 17 NO. 353, INCLUDING THE DEFINITION OF "HEALTH MAINTENANCE
 18 ORGANIZATION", IS NOT PASSED AND APPROVED, THE BRACKETED
 19 LANGUAGE IN SECTION 3(3)(C) OF THIS ACT IS VOID.

20 Section 10. Severability. If a part of this act is
 21 invalid, all valid parts that are severable from the invalid
 22 part remain in effect. If a part of this act is invalid in
 23 one or more of its applications, the part remains in effect
 24 in all valid applications that are severable from the
 25 invalid applications.

1 SECTION 11. APPLICABILITY -- FILING WITH COMMISSIONER.
2 ON OR BEFORE JANUARY 1, 1988, A HEALTH CARE INSURER
3 PERFORMING THE FUNCTIONS ENUMERATED IN THIS ACT SHALL NOTIFY
4 THE COMMISSIONER OF ITS EXISTENCE AND CONTINUE TO OPERATE
5 SUBJECT TO THE PROVISIONS OF THIS ACT.

6 Section 12. Effective date. ~~This act is~~ SECTION 6 7
7 AND THIS SECTION ARE effective on passage and approval.

-End-

CONFERENCE COMMITTEE REPORT

Report No.1.....

April 14, 1987

MR. PRESIDENT

We, your _____ Conference Committee on

SENATE BILL 371

met and considered _____ House Business and Labor Standing Committee

amendments to Senate Bill 371, dated March 26, 1987.

We recommend as follows:

THAT SENATE BILL 371, reference copy salmon, BE AMENDED AS FOLLOWS:

1. Page 6, line 20.

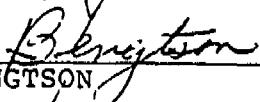
Following: " REIMBURSED. "

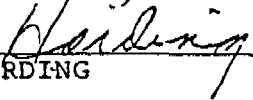
Insert: "The commissioner shall review differences between copayments, deductibles, and other cost-sharing arrangements."

And that this Conference Committee report be adopted.

FOR THE SENATE

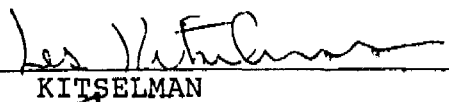


REGAN, CHAIRPERSON

BENGTSON

HARDING

FOR THE HOUSE



KITSELMAN

THOMAS

J. BROWN

ADOPT REJECT

HOUSE

STANDING COMMITTEE REPORT

MARCH 26 19 87

SENATE BILL NO. 371
MARCH 26 19 87
Page 2 of 5

Mr. Speaker: We, the committee on BUSINESS AND LABOR

report SENATE BILL NO. 371

☐ do pass ☒ be concurred in ☒ as amended
☐ do not pass ☐ be not concurred in ☐ statement of intent attached

Les Kitse
 REP. LES KITSELMAN Chairman

AMENDMENTS AS FOLLOWS:

1) Title, line 8
 Following: "PROVIDING AN"
 Insert: "APPLICABILITY DATE AND AN"

2) Page 1, line 12
 Strike: "6"
 Insert: "7"

3) Page 1, line 13
 Strike: "Health Care Reimbursement Reform"
 Insert: "Preferred Provider Agreements"

4) Page 1, line 14
 Following: line 13
 Insert: "Section 2. Purpose. The purpose of {sections 1 through 7} is to allow a health care insurer providing disability insurance benefits to negotiate and contract with health care providers to: (1) provide health care services to its insureds or subscribers at a reduction in the fees customarily charged by the provider; or (2) enter into agreements in which the participating providers accept negotiated fees as payment in full for health care services the health care insurer is obligated to provide or pay for under the health benefit plan."

Renumber: subsequent sections

5) Page 1, line 15
 Strike: "6"
 Insert: "7"

6) Page 2, line 5
 Following: line 4
 Insert: "(3) Health care insurer" means:
 (a) an insurer that provides disability insurance as defined in 33-1-207;
 (b) a health service corporation as defined in 33-30-101;

(c) a health maintenance organization (as defined in section 2 of Senate Bill no. 353);
 (d) a fraternal, benefit society as defined in 33-7-102;
 (e) an administrator as defined in 33-17-601; or
 (f) any other entity regulated by the commissioner that provides health coverage."

Renumber: subsequent subsections

7) Page 2, lines 7 through 9
 Following: "authorization" on line 7
 Strike: the remainder of line 7, line 8 in its entirety, and line 9 through "products"
 Insert: "or services provided under Title 33, chapter 22, part 7"

8) Page 2, lines 14 through 17
 Strike: subsection (5) in its entirety
 Insert: "(6) 'Preferred provider' means a provider or group of providers who have contracted to provide specified health care services.

(7) "Preferred provider agreement" means a contract between or on behalf of a health care insurer and a preferred provider."
 Renumber: subsequent subsection

9) Page 2, line 20
 Strike: "in this state"
 Insert: "or services covered within Title 33, chapter 22, part 7"

10) Page 2, line 21
 Following: line 20
 Insert: "(9) 'Subscriber' means a certificate holder or other person on whose behalf the health care insurer is providing or paying for health care coverage."

11) Page 2, line 23
 Strike: "an"
 Insert: "a health care"

12) Page 2, line 25
 Strike: "The insurer's"

13) Page 3, line 1
 Following: "insureds"
 Insert: "or subscribers on whose behalf the health care insurer is providing health care coverage"
 Following: "including"
 Insert: "preferred provider"
 Following: "to"
 Insert: ": (i)"

14) Page 3, line 2
 Following: ", "
 Insert: "and (ii) the amount and manner of payment to the provider;"

15) Page 3, line 12
 Strike: "ARRANGEMENT"
 Insert: "agreement"

16) Page 3, line 14
 Strike: "MEDICALLY NECESSARY"
 Insert: "health care services"
 Strike: "EXPENSES"

17) Page 3, line 15
 Strike: "6"
 Insert: "7"

18) Page 3, line 22
 Strike: "{2}"

19) Page 3, line 23
 Following: "LEAST"
 Insert: ": (a)"

20) Page 3, line 25
 Strike: "ARRANGEMENT"
 Insert: "agreement"

21) Page 4, line 3
 Following: "PROVIDER"
 Insert: "; and

(b) a provision that clearly identifies the difference in benefit levels for health care services of a preferred provider and benefit levels for the same health care services of a nonpreferred provider"

22) Page 4, line 4
 Following: line 3
 Insert: "(2) A health care insurer may not require hospital staff privileges as criteria for designation as a preferred provider in a preferred provider agreement."

23) Page 4, line 5
 Strike: "ARRANGEMENTS"
 Insert: "agreements"

24) Page 4, line 6
 Strike: "ARRANGEMENT"
 Insert: "agreement"

25) Page 4, line 9
 Strike: "POLICYHOLDERS"
 Insert: "insureds"

26) Page 4, lines 11 through 16
 Following: "(A) A" on line 11
 Strike: the remainder of line 11, lines 12 through 15 in their entirety and line 16 through "ARRANGEMENTS"
 Insert: "provision setting a payment difference for reimbursement of a nonpreferred provider as compared to a preferred provider. If the health benefit plan contains a payment difference provision, the payment difference may not exceed 25% of the reimbursement level at which a preferred provider would be reimbursed"

27) Page 4, line 20
 Following: "OF"
 Strike: "A PROVIDER ARRANGEMENT,"
 Insert: "an"

28) Page 4, line 21
 Following: "POLICY"
 Strike: "I"
 Following: "CONTRACT"
 Insert: "except those already approved by the commissioner,"

29) Page 4, line 24, through page 5, line 1
 Following: "rules" on line 24
 Strike: the remainder of line 24, lines 25 and 1 in their entirety
 Insert: "necessary to implement the provisions of"

Lee Whitman

Chairman.

Lee Whitman

Chairman.

30) Page 5, line 2
Strike: "6"
Insert: "7"

31) Page 5, line 4
Strike: "6"
Insert: "7"

32) Page 5, line 6
Strike: "6"
Insert: "7"

33) Page 5, line 7
Following: line 6
Insert: "Section 9. Coordination instruction. If Senate Bill No. 353, including the definition of "health maintenance organization", is not passed and approved, the bracketed language in section 3(3)(c) of this act is void."

Renumber: subsequent sections

34) Page 5, line 13
Following: line 12
Insert: "Section 11. Applicability -- filing with commissioner. On or before January 1, 1988, a health care insurer performing the functions enumerated in this act shall notify the commissioner of its existence and continue to operate subject to the provisions of this act."

Renumber: subsequent section

35) Page 5, line 13
Strike: "6"
Insert: "7"

Lee Whitman
Chairman.

1 STATEMENT OF INTENT

2 SENATE BILL 371

3 Senate Public Health, Welfare, and Safety Committee
4

5 A statement of intent is required for this bill because
6 section 6 authorizes the commissioner of insurance to
7 promulgate rules prescribing reasonable standards relating
8 to the accessibility and availability of health care
9 services for persons insured under policies or contracts
10 described in section 3. The legislature intends that the
11 rules adopted to implement this bill be designed to:

12 (1) foster accessibility and availability of health
13 care services; and

14 (2) protect Montana health care insurance consumers.

15 The legislature further intends that the commissioner
16 adopt rules to implement this act in accordance with
17 33-1-313, which permits the commissioner:

18 (1) to make only reasonable rules that do not extend,
19 modify, or conflict with any law of this state or with any
20 reasonable implication of such law; and

21 (2) to make or amend those rules only after a hearing
22 of which notice has been given as required by 33-1-703.

SENATE BILL NO. 371

INTRODUCED BY REGAN, HIMSL

A BILL FOR AN ACT ENTITLED; "AN ACT PERMITTING INSURERS TO ENTER INTO AGREEMENTS WITH HEALTH CARE PROVIDERS AND TO ISSUE POLICIES THAT INCLUDE INCENTIVES OR ~~---LIMIT~~ REIMBURSEMENT FOR UTILIZING SERVICES RENDERED BY PROVIDERS WITH WHOM THE INSURER HAS AN AGREEMENT; AND PROVIDING AN IMMEDIATE APPLICABILITY DATE AND AN EFFECTIVE DATE."

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF MONTANA:

Section 1. Short title. [Sections 1 through 4 6 7] may be cited as the "Health-Care-Reimbursement-Reform PREFERRED PROVIDER AGREEMENTS Act".

SECTION 2. PURPOSE. THE PURPOSE OF [SECTIONS 1 THROUGH 7] IS TO ALLOW A HEALTH CARE INSURER PROVIDING DISABILITY INSURANCE BENEFITS TO NEGOTIATE AND CONTRACT WITH HEALTH CARE PROVIDERS TO:

(1) PROVIDE HEALTH CARE SERVICES TO ITS INSUREDS OR SUBSCRIBERS AT A REDUCTION IN THE FEES CUSTOMARILY CHARGED BY THE PROVIDER; OR

(2) ENTER INTO AGREEMENTS IN WHICH THE PARTICIPATING PROVIDERS ACCEPT NEGOTIATED FEES AS PAYMENT IN FULL FOR HEALTH CARE SERVICES THE HEALTH CARE INSURER IS OBLIGATED TO PROVIDE OR PAY FOR UNDER THE HEALTH BENEFIT PLAN.

Section 3. Definitions. As used in [sections 1 through 4 6 7], the following definitions apply:

(1) "EMERGENCY SERVICES" MEANS SERVICES PROVIDED AFTER SUFFERING AN ACCIDENTAL BODILY INJURY OR THE SUDDEN ONSET OF A MEDICAL CONDITION MANIFESTING ITSELF BY ACUTE SYMPTOMS OF SUFFICIENT SEVERITY (INCLUDING SEVERE PAIN) THAT WITHOUT IMMEDIATE MEDICAL ATTENTION THE SUBSCRIBER OR INSURED COULD REASONABLY EXPECT THAT:

(A) HIS HEALTH WOULD BE IN SERIOUS JEOPARDY;

(B) HIS BODILY FUNCTIONS WOULD BE SERIOUSLY IMPAIRED;

OR

(C) A BODILY ORGAN OR PART WOULD BE SERIOUSLY DAMAGED.

(2) "HEALTH BENEFIT PLAN" MEANS THE HEALTH INSURANCE POLICY OR SUBSCRIBER ARRANGEMENT BETWEEN THE INSURED OR SUBSCRIBER AND THE HEALTH CARE INSURER THAT DEFINES THE COVERED SERVICES AND BENEFIT LEVELS AVAILABLE.

(3) "HEALTH CARE INSURER" MEANS:

(A) AN INSURER THAT PROVIDES DISABILITY INSURANCE AS DEFINED IN 33-1-207;

(B) A HEALTH SERVICE CORPORATION AS DEFINED IN 33-30-101;

(C) A HEALTH MAINTENANCE ORGANIZATION (AS DEFINED IN SECTION 2 OF SENATE BILL NO. 353);

(D) A FRATERNAL BENEFIT SOCIETY AS DEFINED IN 33-7-102;

(E) AN ADMINISTRATOR AS DEFINED IN 33-17-601; OR

(F) ANY OTHER ENTITY REGULATED BY THE COMMISSIONER THAT PROVIDES HEALTH COVERAGE.

~~(1)(3)(4)~~ "Health care services" means health care services or products rendered or sold by a provider within the scope of the provider's license or legal authorization, including--but--not--limited--to--hospital--medical--surgical--dental--vision--and--pharmaceutical--services--and--products OR SERVICES PROVIDED UNDER TITLE 33, CHAPTER 22, PART 7.

~~(2)(4)(5)~~ "Insured" means an individual entitled to reimbursement for expenses of health care services under a policy or subscriber contract issued or administered by an insurer.

~~(3)(5)--"insurer"--means--an--insurance--company--or--a health-service-corporation-authorized-in-this-state-to-issue policies--or--subscriber-contracts-that-reimburse-an-insured for-expenses-of-health-care-services~~

(6) "PREFERRED PROVIDER" MEANS A PROVIDER OR GROUP OF PROVIDERS WHO HAVE CONTRACTED TO PROVIDE SPECIFIED HEALTH CARE SERVICES.

(7) "PREFERRED PROVIDER AGREEMENT" MEANS A CONTRACT BETWEEN OR ON BEHALF OF A HEALTH CARE INSURER AND A PREFERRED PROVIDER.

~~(4)(6)(8)~~ "Provider" means an individual or entity licensed or legally authorized to provide health care

~~services in-this-state~~ OR SERVICES COVERED WITHIN TITLE 33, CHAPTER 22, PART 7.

(9) "SUBSCRIBER" MEANS A CERTIFICATE HOLDER OR OTHER PERSON ON WHOSE BEHALF THE HEALTH CARE INSURER IS PROVIDING OR PAYING FOR HEALTH CARE COVERAGE.

Section 4. Preferred provider agreements authorized.

(1) Notwithstanding any other provision of law to the contrary, an A HEALTH CARE insurer may:

(a) enter into agreements with providers relating to health care services that may be rendered to ~~the--insurer's~~ insureds OR SUBSCRIBERS ON WHOSE BEHALF THE HEALTH CARE INSURER IS PROVIDING HEALTH CARE COVERAGE, including PREFERRED PROVIDER agreements relating to:

(I) the amounts an insured may be charged for services rendered; AND

(II) THE AMOUNT AND MANNER OF PAYMENT TO THE PROVIDER; and

(b) issue or administer policies or subscriber contracts in this state that:

~~(i)~~ include incentives for the insured to use the services of a provider that has entered into an agreement with the insurer pursuant to subsection (1)(a); or

~~(ii)--provide-for-reimbursement-for-health-care-services only--if--the--services--are-rendered-by-a-provider-that-has entered-into-an--agreement--with--the--insurer--pursuant--to~~

~~subsection (1)(a):~~

(2) A PREFERRED PROVIDER ARRANGEMENT AGREEMENT ISSUED OR DELIVERED IN THIS STATE MAY NOT UNFAIRLY "DENY HEALTH BENEFITS FOR MEDICALLY-NECESSARY HEALTH CARE SERVICES COVERED EXPENSES.

(2)(3) [Sections 1 through 4 6 7] do not require that an insurer negotiate or enter into agreements with any specific provider or class of providers.

SECTION 5. INCENTIVES IN HEALTH BENEFIT PLANS. (1) A HEALTH CARE INSURER MAY ISSUE A POLICY OR A HEALTH BENEFIT PLAN THAT PROVIDES FOR INCENTIVES FOR COVERED PERSONS TO USE THE HEALTH CARE SERVICES OF PREFERRED PROVIDERS.

(2) THE POLICY OR HEALTH BENEFIT PLAN MUST CONTAIN AT LEAST:

(A) A PROVISION THAT IF A COVERED PERSON RECEIVES EMERGENCY CARE FOR SERVICES SPECIFIED IN THE PREFERRED PROVIDER ARRANGEMENT AGREEMENT AND CANNOT REASONABLY REACH A PREFERRED PROVIDER, THE CARE RENDERED DURING THE COURSE OF THE EMERGENCY WILL BE REIMBURSED AS THOUGH THE COVERED PERSON HAD BEEN TREATED BY A PREFERRED PROVIDER; AND

(B) A PROVISION THAT CLEARLY IDENTIFIES THE DIFFERENCE IN BENEFIT LEVELS FOR HEALTH CARE SERVICES OF A PREFERRED PROVIDER AND BENEFIT LEVELS FOR THE SAME HEALTH CARE SERVICES OF A NONPREFERRED PROVIDER.

(2) A HEALTH CARE INSURER MAY NOT REQUIRE HOSPITAL

STAFF PRIVILEGES AS CRITERIA FOR DESIGNATION AS A PREFERRED PROVIDER IN A PREFERRED PROVIDER AGREEMENT.

SECTION 6. PERMISSIBLE PROVISIONS IN PROVIDER ARRANGEMENTS AGREEMENTS, INSURANCE POLICIES, AND SUBSCRIBER CONTRACTS. (1) A PROVIDER ARRANGEMENT AGREEMENT, INSURANCE POLICY, OR SUBSCRIBER CONTRACT ISSUED OR DELIVERED IN THIS STATE MAY CONTAIN CERTAIN OTHER COMPONENTS DESIGNED TO CONTROL THE COST AND IMPROVE THE QUALITY OF HEALTH CARE FOR POLICYHOLDERS INSURED AND SUBSCRIBERS, INCLUDING:

(A) A PAYMENT--DIFFERENTIAL--OF--NOT--MORE--THAN--25% BETWEEN--USE--OF--PROVIDERS--WITH--ARRANGEMENTS--WITH--THE--HEALTH CARE--INSURER--AND--USE--OF--PROVIDERS--WITHOUT--SUCH--ARRANGEMENTS--THE--COMMISSIONER--MAY--BY--RULE--DETERMINE--APPROPRIATE DIFFERENTIALS--BETWEEN--COPAYMENTS,--DEDUCTIBLES,--AND--OTHER COST--SHARING--ARRANGEMENTS PROVISION SETTING A PAYMENT DIFFERENCE FOR REIMBURSEMENT OF A NONPREFERRED PROVIDER AS COMPARED TO A PREFERRED PROVIDER. IF THE HEALTH BENEFIT PLAN CONTAINS A PAYMENT DIFFERENCE PROVISION, THE PAYMENT DIFFERENCE MAY NOT EXCEED 25% OF THE REIMBURSEMENT LEVEL AT WHICH A PREFERRED PROVIDER WOULD BE REIMBURSED. THE COMMISSIONER SHALL REVIEW DIFFERENCES BETWEEN COPAYMENTS, DEDUCTIBLES, AND OTHER COST-SHARING ARRANGEMENTS.

(B) CONDITIONS, NOT INCONSISTENT WITH OTHER PROVISIONS OF [SECTIONS 1 THROUGH 6], DESIGNED TO GIVE POLICYHOLDERS OR SUBSCRIBERS AN INCENTIVE TO CHOOSE A PARTICULAR PROVIDER.

(2) ALL TERMS OR CONDITIONS OF A-PROVIDER-ARRANGEMENT, AN INSURANCE POLICY, OR SUBSCRIBER CONTRACT, EXCEPT THOSE ALREADY APPROVED BY THE COMMISSIONER, ARE SUBJECT TO THE PRIOR APPROVAL OF THE COMMISSIONER.

Section 7. Rules. The commissioner shall promulgate rules prescribing--reasonable--standards--relating--to--the accessibility--and--availability--of--health--care--services--for persons--insured--under--policies--or--contracts--described--in NECESSARY TO IMPLEMENT THE PROVISIONS OF (section 31)(b)(1) SECTIONS 1 THROUGH 6'7).

Section 8. Codification instruction. Sections 1 through 4 6 7 are intended to be codified as an integral part of Title 33, and the provisions of Title 33 apply to sections 1 through 4 6 7.

SECTION 9. COORDINATION INSTRUCTION. IF SENATE BILL NO. 353, INCLUDING THE DEFINITION OF "HEALTH MAINTENANCE ORGANIZATION", IS NOT PASSED AND APPROVED, THE BRACKETED LANGUAGE IN SECTION 3(3)(C) OF THIS ACT IS VOID.

Section 10. Severability. If a part of this act is invalid, all valid parts that are severable from the invalid part remain in effect. If a part of this act is invalid in one or more of its applications, the part remains in effect in all valid applications that are severable from the invalid applications.

SECTION 11. APPLICABILITY -- FILING WITH COMMISSIONER.

ON OR BEFORE JANUARY 1, 1988, A HEALTH CARE INSURER
PERFORMING THE FUNCTIONS ENUMERATED IN THIS ACT SHALL NOTIFY
THE COMMISSIONER OF ITS EXISTENCE AND CONTINUE TO OPERATE
SUBJECT TO THE PROVISIONS OF THIS ACT.

Section 12. Effective date. ~~This act is~~ SECTION 6 7
AND THIS SECTION ARE effective on passage and approval.

-End-